Goals and Objectives

Goals
- Provide billing information to insure compensation for services
- Assist understanding of illegal billing practices

Objectives: After this program students should be able to:
- Identify billing practices that are fraudulent
- Prevent themselves and others from involvement in fraudulent billing practices

Fraud

A deliberate deception
For unfair or unlawful gain
"Purposeful" Fraud

- Dispense generic Rx - bill for brand Rx
- Dispense nothing - bill for drug
- Dispense one strength - bill for another
- Acquire drug samples - bill for them
- Acquire non-retail drugs (e.g. VA, foreign drugs, etc. and bill for them)
- Fee splitting

- Misrepresentations on applications
  - Professional degrees (e.g. not state-licensed)
  - practice status (e.g. license suspended)
  - shareholder histories (e.g. hx of crime)
  - medical directors (e.g. lack of permission)
  - previous actions, etc

- Ghost patients
- Unnecessary services, false referrals
- Participating provider-patient payments
- Services provided by non-pharmacists
- Antitrust activities
  - "Price fixing", collusion (secret agreements or cooperation for deceitful purpose)

- One party offers money or some other form of inducement to another party in return for increased (Medicare or Medicaid) business
- Corrupts provider’s decision-making process and encourages actions not in the patient’s best interest
Purposeful Fraud

Upcoding

- Provision of one service but charging for another, more profitable (or permissible) one
- Pharmacists may be more susceptible to this when providing pharmaceutical care services (e.g. MTM)

Unbundling

- The whole is sometimes worth less than the sum of its parts
- Example: bill for lipid panel by billing separately for TC, HDL, LDL, TRGs, etc
- Flu Vaccinations billed to Medicaid by billing vaccine and for syringe

“Unwitting” Fraud

- Prescriptions billed but not picked up
- Medicare patients paying for services*
- Price database and algorithm errors
- Wrong billing code assigned to service
- Incorrect provider numbers
- Dates of service changed
- Undocumented services

Medicare Part D

- Much larger exposure to fraud against the federal government:
  - Prescription Drug Plans (PDPs) required to monitor & report pharmacy:
    - Prescription reversals
    - MTM Oversight:
      - patient eligibility
      - Fraud, waste and abuse
    - Generic dispensing
    - Grievances
    - Prior authorizations & formulary exceptions
    - Overpayments
    - Licensure
Medicare/Medicaid Provider Participation

- Accepting assignment
  - Illegal patient payments: i.e. Immunizations, covered DME
- OBRA-90 mandate (federal) for Medicaid participation (state)
  - Prospective DUR: screen Rxs, counsel patients, document relevant information

Rules for Participation

- Licensed to practice in the state in which you are applying?
- Ever been excluded from Medicare?
- Have civil or monetary penalties ever been levied against you by the Medicare or Medicaid programs?
- Do you have ownership in other organizations that bill M’care/M’caid?

False Claims Act and Qui Tam Actions

- False claims act 1863, amended 1986
  - Qui tam pro domino rege quam pro si ipso in hac parte sequitor
    - “he who brings the action as well for the king as for himself”

Expanded enforcement activities

- Increased penalties, relator (whistleblower) role increased
- 32 qui tam cases in ‘87, over 500 ‘97 w/ over $600mil. recovered;
- Total through 2004: $9 billion
- $6 billion from healthcare alone
**Penalties**

- Criminal, civil and administrative
  - Civil: $5,500-11,000 per false claim & treble damages under false claims act
  - HIPAA*: criminal fines &/or imprisonment of up to 10 years
  - M’care/M’caid anti-kickback statute: imprisonment up to 5 yrs, fines up to $25,000
  - Debarment, exclusion, licensure
  - Loss of pharmacy’s public trust & respect

*Healthcare Insurance Portability and Accountability Act

**Damages**

- Damages under the False Claims Act are severe. A person who violates the act must repay three times the amount of damages suffered by the government plus a mandatory civil penalty of at least $5,500 and no more than $11,000 per claim, for all claims made after September 29, 1999.

**Damages**

- This means that, for example, a person who submits fifty false prescription claims to Medicaid or Medicare for fifty dollars each is liable for between:
  - $282,500 \[($2,500 \times 3) + (50 \times $5,500)\] &
  - $557,500 \[($2,500 \times 3) + (50 \times $11,000)\]

  in damages under the False Claims Act.

**Discovery**

- Audits (e.g. PBMs)
- Board of Pharmacy inspections; complaints
- Wholesalers
- Manufacturer reps
- Consumers
- Providers
- Fellow employees
National Fraud Hotline
(CMS)

- 1-800-HHS-tips
  - Recipient’s name
  - Recipient’s Medicaid/Medicare number
  - Provider’s name
  - Date of service
  - Amount approved by Medicaid/Medicare
  - Description of fraudulent or abusive act